The Project HOPE
CENTER for HEALTH AFFAIRS

A REVIEW OF PRIVATE SECTOR PAYMENT METHODOLOGIES FOR HOSPITAL OUTPATIENT SERVICES

Final Report

September 8, 1989

Prepared under Cooperative Agreement No. 99-C-99168/3-01
Project HOPE HCFA Health Policy Research Center

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TABLE OF CONTENTS

Section		Page
SUMMARY		iii
SECTION 1.	INTRODUCTION	
1.1	The Congressional Mandate	1-1
1.2	Overview of the Research Approach	1-4
SECTION 2.	COLLECTING AND SYNTHESIZING INFORMATION	
2.1	Selection of Private Payers to Contact	2-1
2.2	Process for Gathering Information	2-2
2.2.1	Determining the Number of Payers to Contact	2-2
2.2.2	Identifying the Most Knowledgeable Persons	2-3
2.2.3	Determining the Presence of a Prospective Payment Plan	2-5
2.2.4	Gathering Follow-up Information	2-7
SECTION 3.	DESCRIPTION OF GENERAL FINDINGS	
3.1	General Findings	3-1
3.2	The Scarcity of Prospective Plans and Current Payment Methods	3-3
3.2.1	Potential Reasons Why Prospective Plans are Not More Prevalent	3-3
3.2.2	Current Payment Methods	3-4
SECTION 4.	DESCRIPTION OF PROSPECTIVE PLANS	
4.1	Overview	4-1
4.2	General Features of the Prospective Plans	4-2
4.2.1	Types of Services	4-2
4.2.2	Data Requirements	4-5
4.2.3	Payment Unit and Establishment of Payment Rates	4-6
4.3	Possible Limitations For Plan Effectiveness	4-8
4.3.1	Lack of Substantial Market Power	4-8
4.3.2	Data Limitations	4-9
4.4	Plans Under Development And Future Trends	4-10
SECTION 5.	CONCLUSIONS AND IMPLICATIONS FOR HCFA	
REFERENCES		R-1

TECHNICAL APPENDICES

APPENDIX A. Snyopses of Plans with Written Documentation of Payment Methods

APPENDIX B. Snyopses of Plans for which Information was Collected over the Telephone, and Synopses of Plans Under Development

EXECUTIVE SUMMARY

Under Section 9343(f) of the Omnibus Budget Reconciliation Act of 1986 (OBRA-86), Congress instructed the Secretary of Health and Human Services to develop a fully prospective payment system for hospital outpatient ambulatory surgical services, and to study a model system for nonsurgical hospital outpatient services. The reports submitted to Congress as part of this mandate will analyze payment for the facility component rather than the physician component of outpatient surgical and medical services.

To assist HCFA in meeting this mandate, this project: 1) gathers information on the types of private sector prospective payment systems that have been developed or are under development for outpatient hospital or ambulatory surgery center (ASC) services; and 2) discusses the contributions that private sector prospective payment systems could make toward the design of a prospective system under Medicare.

In order to gather information on the prospective payment plans that have been developed in the private sector for hospital outpatient and ASC services, we contacted by telephone over 180 private insurers, preferred provider organizations, large corporations, third-party administrators, utilization firms, and business coalitions. Based on our telephone conversations, we established that only 15 of these organizations have prospective systems, 12 of which are in place, and three of which are under development. Eight of the plans in place and two under development were initiated by Blue Cross/Blue Shield (BC/BS) member plans.

The systems that are currently being used in the private sector are not as elaborate as are the systems being explored by public sector payers. For example, the plans in use have not gone so far as to incorporate patient characteristics as a means of more ably predicting the amount of resources used in a defined service. By contrast, the development of such a patient classification system forms the basis of the work being done by Health Services International with their Ambulatory Visit Groups (AVGs) and the New York State Department of Health with their Products of Ambulatory Care (PACs) and Products of Ambulatory Surgery (PASs).

Administrative simplicity of the system was a major consideration for private third party payers. This resulted, for the most part, in the establishment of prospective rates for relatively few payment categories (e.g., four to twenty-five), the definition of which commonly centers around a two to three digit ICD-9-CM procedure code. A few of the plans had incorporated the payment groups used in Medicare's payment system

for outpatient procedures. However, only three plans were using systems that group procedures by relative resource use. None of these organizations had done a systematic evaluation of how well the established payment groups predict resource use.

Eleven of the twelve plans in use have established prices for ambulatory surgical procedures. As it is much easier to define a unit of care and resource use does not vary as widely for surgical procedures as it does for medical procedures, this focus is not surprising. Nearly half of these plans target high cost/high volume procedures for prospective pricing. Targeted procedures include: cataract lens procedures; arthroscopies; endoscopies; laparoscopies; cystoscopies; and tonsillectomies, to name a few. The number of surgical procedures incorporated in the payment groups varied from 50 to over 1400 procedures.

Only two plans paid for medical services prospectively. One had established payment categories for such services as radiation therapy, renal dialysis, chemical dependency, and nervous and mental disorders. The other had developed a five-tiered payment system for emergency services that depended upon simple patient characteristics (e.g., whether the patient was conscious or breathing), and disposition of the case (e.g., admitted as an inpatient, death). In the latter case, distinction between the payment categories was blurred leaving great potential for "gaming" the system and maximizing reimbursement.

Payment rates were most often established through the use of charge data (as opposed to cost data) and a competitive bid process or negotiations with individual providers. In this manner, payment rates were tailored to individual facilities. Contract negotiations often included the establishment of a trend factor (e.g., the medical CPI or the overall CPI) for payment rates in multi-year contracts. Most contracts prohibited balance billing. In only two instances were rates established by plans that were binding for all facilities in an area. Both of these plans mentioned problems with provider participation.

Of the three plans under development, only two substantially depart from systems currently in use. Blue Cross/Blue Shield of Western Pennsylvania has been exploring the possibility of using Patient Management Categories (PMCs), which group Uniform-Bill 82 revenue codes by relative costs, for outpatient reimbursement. This project has been hindered by a lack of adequate billing data. Empire Blue Cross/Blue Shield is seeking funding for the development of Acute Patient Care Episodes. The focus of this research is on the definition of an episode of care. The complete episode is likely to include early diagnostic visits. Due to the difficulty in predicting a course of treatment from initial visits, it may not be feasible to use this system for prospective reimbursement. However, it is anticipated that clarification of episodes of acute care could be useful for

utilization review.

The lack of innovative private sector systems and the relative weakness of those that exist, despite the apparent interest, suggests the magnitude of the operational difficulties faced in prospective pricing for outpatient services. Two major constraints faced by private payers have been the lack of adequate cost data for outpatient services and the lack of market buying power. In the first instance, the absence of procedure codes on provider bills hinders the development of payment categories based on charges. Even claims that incorporate ICD-9-CM procedure codes display wide charge variation within a particular facility as well as between facilities. Effective prospective pricing is partially dependent an ability to assess the resource use, or costs, of a particular outpatient service. However, few private payers command the market power necessary to make cost reports mandatory. This is compounded by the fact that even payers with access to cost information are unable to obtain fine enough detail to allocate costs to individual procedures. Market power is also an important factor in a payers ability to set prices. Although coalitions that negotiate annual price agreements with facilities are not uncommon (e.g., preferred provider agreements), many private payers lack an ability to set prices prospectively. For this reason, it is not too surprising that BC/BS plans which are more likely to have substantial market penetration are also more likely to be actively involved in prospective payment for outpatient services.

We conclude that, at the present time, there are not likely to be any major components of private payer systems that could substantially contribute toward the design of a system under Medicare. Private payers are still looking to Medicare to play a leading role in this area. Despite the operational difficulties involved in the development of a prospective pricing system for outpatient services, Medicare may be better situated to develop a successful system because of both better access to better data and greater buying power.

SECTION 1. INTRODUCTION

1.1 THE CONGRESSIONAL MANDATE

There is increasing concern in both the public and private sectors over the rapid growth in expenditures for medical and surgical services provided in hospital outpatient departments. As evidence, hospital outpatient visits, from 1983 to 1986, rose at an average annual rate of 10.4 percent, while increasing only 3.8 percent, on average, between 1980 to 1983 (AHA 1981; AHA 1984; AHA 1987).

Medicare expenditures have been increasing rapidly as well. For example, from 1983 to 1986, Medicare reimbursement for hospital outpatient services increased as a proportion of total Medicare reimbursement (4.6 to 6.5 percent) (Bowen, 1988). Surgery accounted for most of the relative increase in Medicare reimbursement from 1984 to 1985 (Bowen, 1988).

In efforts to slow the rate of increase in outpatient costs, Congress has limited payments for clinical laboratory, radiology, and most recently, ambulatory surgical services. The Omnibus Budget Reconciliation Act of 1986 (OBRA-86) also contains language that could lead to more sweeping changes in hospital outpatient reimbursement. Section 9343(f) of OBRA-86 calls for:

1) The development of a fully prospective payment system for hospital outpatient ambulatory surgical procedures.

2) An all-inclusive, appropriate payment rate which includes facility services and all other medical and health services, excluding those provided by a physician.

3) Rates that take into account the extent to which cost differences between hospitals and ambulatory surgery centers are justifiable.

Under the mandate, the Secretary of Health and Human Services was required to submit an interim report on the development of the payment system by April 1, 1988, and a final report by April 1, 1989. The final report was to include recommendations concerning the implementation of the system for patients undergoing surgical procedures on or after October 1, 1989. The Secretary also is required to develop a model system for nonsurgical ambulatory hospital services and report on the system by January 1, 1991.

In support of this mandate, HCFA is currently funding five contractors to examine existing prospective payment systems for outpatient services and to assess methodological aspects of designing such a system. These contractors include Project HOPE, the New York State Department of Social Services, Health Systems International (HSI), Brandeis University, and the Urban Institute.

Aside from Project HOPE, the other contractors are involved in developmental projects that focus on outpatient classification systems and on methodological issues in the design of a hospital outpatient prospective payment system. The New York State (NYS) Department of Social Services is developing a case-mix adjusted prospective payment system for ambulatory medical services. The classification system, called Products of Ambulatory Care (PACs), groups patients into one of 24 payment categories based on patient clinical and demographic characteristics and resource use. NYS is also developing a system called Products of Ambulatory Surgery (PASs) for ambulatory surgical services that is based on a similar methodological approach. HSI is refining the Ambulatory Visit Groups (AVGs) patient classification system, originally developed by Yale University. Their intention is to roughly halve the 571 payment categories, while expanding the number of outpatient procedures included in the system.

Brandeis University and the Urban Institute are both evaluating alternative methodologies for patient classification. Brandeis is examining the relative effectiveness of AVGs and Diagnostic Related Groups (DRGs) in explaining variation in resource use for Medicare hospital outpatient and ambulatory surgery center (ASC) services. The Brandeis study will suggest an ambulatory surgery payment system based either on AVGs or DRGs or some combination of the two.

The Urban Institute is analyzing the utilization and cost information necessary for designing a prospective payment system for outpatient surgical procedures. Their study involves creation of a unique data base and analysis of: 1) the factors that influence variation in the cost of performing surgery; 2) the procedure-related services that should be included within the payment rate, 3) the appropriate levels of payment rates, and 4) the implications of various payment levels for facility revenues, program costs, and patient access. The Urban Institute project complements the work being done at Brandeis and will provide HCFA with more insight into the effects of various rate-setting and classification methodologies.

In this particular study, Project HOPE provides HCFA with information on private sector payment methods that have been established to pay prospectively for hospital outpatient medical and surgical services, and ASC services. A detailed knowledge of the design and implementation of private sector payment systems will assist HCFA in meeting its mandate under Section 9343(f) of OBRA-86.

1.2 OVERVIEW OF THE RESEARCH APPROACH

The approach to this project had four major steps:

1) Compiling a list of private organizations that may have insurance plans covering hospital outpatient services and/or ASC services for which payment is established prospectively;

2) Contacting such organizations and obtaining both written and oral documentation of the relevant prospective payment plans;

3) Synthesizing this information in a clear and concise manner; and

4) Drawing conclusions about aspects of these plans that might be valuable to HCFA in meeting its Congressional mandate.

The remainder of the report is organized as follows. Section 2 describes the methods used both for selecting private payers and establishing if they have or are developing a prospective payment plan. Section 3 provides a summary of the number of plans that were found which have prospective payment and offers possible reasons why such plans are not highly prevalent. A description of these prospective payment plans is found in Section 4. Finally, Section 5 discusses the relevance of the private payer prospective systems for HCFA's mandate from Congress. Appendix A provides synopses of the prospective plans for which written documentation was supplied. Synopses of those plans for which information was collected over the telephone and synopses of plans under development appear in Appendix B.

SECTION 2. COLLECTING AND SYNTHESIZING INFORMATION

2.1 SELECTION OF PRIVATE PAYERS TO CONTACT

Our first task was to develop a list that includes organizations that might have prospective payment systems for their insurance plans covering hospital outpatient services or ASC services. Three steps were undertaken in order to develop this list. First, various entities involved with medical benefits were contacted and the potential "leads" they provided were included on the list of organizations to contact.

The sources for leads included, as listed below, insurance company trade associations, corporate benefits trade associations, and other relevant private organizations:

- The Blue Cross/Blue Shield Association
- The Health Insurance Association of America
- The Employee Benefits Research Institute
- The Washington Business Group on Health
- The Society of Professional Benefits Administrators
- The American Association of Preferred Provider Organizations

In the second step, as outlined below, organizations with a large market share were identified through trade publications and directories, and included on the list. Large organizations were deemed more likely than smaller ones to have prospective plans.

- The top-ranked health insurers were identified in Best Review, while the top-ranked preferred provider organizations (PPOs) were identified by the American Association of Preferred Provider Organizations.
- The top-ranked corporations from the Fortune 500 were identified through Fortune magazine.

- Third-party administrators (TPAs) and utilization review (UR) firms were ranked based on listings appearing in Business Insurance.

- Business coalitions that are actively involved in reimbursement and that also have a relatively large budget to work with were identified in the American Hospital Association's Directory of Health Care Coalitions in the United States.

Finally, in each of the telephone contacts made, individuals were also asked to identify other organizations that may have, or may be developing, prospective payment systems for hospital outpatient or ASC services. These other leads were added to our contact list and the relevant persons were also contacted by telephone. In this way, we attempted to reduce the chance that organizations with prospective payment systems for outpatient services would be overlooked.

2.2 PROCESS FOR GATHERING INFORMATION

We gathered information from over 180 different private payers. This section describes our methods for determining the number of payers to contact, identifying the most knowledgeable persons to speak with, determining the presence of prospective payment systems, and gathering follow-up information.

2.2.1 Determining the Number of Payers to Contact

The universe of private payers exceeds the number that could be contacted within the scope of this project. There are literally thousands of payers that could have been contacted through a larger effort. We attempted to narrow down the potential number of contacts by developing a list of payers to contact (as described above).

Our approach to determining the total number of payers to call, and the distribution of payers, was affected by our operational experience. In terms of the distribution of payers, we believed at the outset that it would be most useful to contact all of our initial leads and then to call a fixed proportion of each type of payer. However, it became clear that certain types of organizations were less likely than others to have prospective payment plans (e.g., business coalitions and corporations both were less likely than insurers to have such plans). Thus, we concentrated our effort more toward insurers. Despite this emphasis, we also contacted enough of the other types of payers to ensure that prospective plans would not be missed.

The number of plans to contact was partly affected by the extent to which payers would or would not respond to our calls. In general, we were persistent in attempting to gather information, and would not give up on a payer unless contact could not be made even after five or more calls. Additionally, some organizations that were contacted refused to take part in the survey. In order to obtain a large number of responses, we passed over those payers who would not answer our calls or refused to take part--only twelve organizations in total.

The time expended in obtaining information varied greatly by the type of payer, and affected the overall number of payers that were contacted. It was clear that the larger the organization, the greater the effort that was involved in making contact and collecting the appropriate information. Generally, the insurers were the most difficult in this regard because it took many phone calls to reach the most knowledgeable persons.

2.2.2 Identifying the Most Knowledgeable Persons

While for some payers it was rather straightforward to ask for and locate the most knowledgeable persons to speak with, this

was not always the case. For many TPAs and UR firms, we were able to obtain contact names from leads, and in other cases we simply asked for the President of the organization. The same was true of all of the business coalitions that were contacted, except that we asked for the Executive Director. The most knowledgeable persons at the PPOs were also relatively easy to contact; we typically asked for the Manager of Provider Negotiations.

For corporations, there were a number of job titles that were relevant. For example, we usually asked to speak with the Director of Medical Benefits, and either gathered information directly from this individual or were put in contact with other staff members (e.g., the Employee Benefits Director, or the Claims Administrator). Identifying the most knowledgeable persons was a relatively simple task.

It was much more difficult to locate the most knowledgeable persons in private insurance companies. In many cases, the telephone number we were provided with was for general claims information. However, we usually asked for individuals with job titles such as Director of Group Managed Care, Director of Medical Claims, Manager of Benefit Operations, and Manager of Cost Containment. The individuals we ultimately were put in contact with often had very different titles, which at least partly seems to reflect the varying organizational structure of insurers.

To summarize, it was sometimes difficult to get in touch with the individuals most knowledgeable about their organization's prospective payment plans, and we cannot be absolutely sure that in all instances we spoke with the most appropriate individual. Nonetheless, we feel that in the vast majority of cases we made informative contacts and collected valid information.

2.2.3 Determining the Presence of a Prospective Payment Plan

The companies and self-insured corporations on the list were contacted by telephone to establish at the outset whether or not they have prospective payment systems for any of their plans that cover hospital outpatient or ASC services. Note that we were only interested in information about the facility component of outpatient services, rather than the physician component.

The types of non-physician or facility services associated with surgery that a payer might be billed for include laboratory and x-ray services as well as many of the services that are part of Medicare reimbursement for ASCs. These include: nursing and technician services, facility usage, on-site drugs, biologicals, surgical dressings, splints, casts, equipment directly related to the provision of the procedure, materials for anesthesia, and administrative, record keeping, and housekeeping items and services (Bowen, 1988). The facility services that are associated with medical care would include many of these same categories with the exception of surgical dressings, splints, casts, anesthesia materials, and some portion of facility usage (i.e., the operating room).

The definition of the term "prospective" in the health care reimbursement field means many different things to many different people. In our discussions with payers, we intended to convey the term "prospective" in a broad fashion to ensure that relevant information would not be excluded from the study.

For the purposes of the study, we defined prospective payment in two distinct levels. At the broadest level, we defined it very simply as "the establishment of pre-set payment rates" for the facility portion of hospital outpatient or ASC services. Clearly, the classic sense of "prospective" is a payment rate established in advance of the rate year. While we

avoided being bound to the terminology of "prospective payment," not all payers defined "pre-set" rates in the same way. There was wide variation in the contact persons' understanding of "pre-set" rates. Some people responded directly that they did not have prospective payment rates thus illustrating their comprehension of what we were seeking to discover. Others did not understand as well.

The individuals who seemed puzzled by the question seemed to interpret pre-set rates in a different manner (e.g., as discounts from charges). In such cases, persons were asked more probing questions (aside from the question all contacts were asked--were they in the process of developing a prospective payment system). For instance, they were asked if they could provide examples of how payment rates are currently established so that we could decide if such a system was indeed prospective. Because of possible differences in interpretation of what we were asking, we sought documentation from plans even if they appeared unlikely to have a system with pre-set rates.

At a more specific level, we reviewed the plans with pre-set rates to determine if cost or charges in the rate-year influenced the payment rate over the course of the year. If this was the case (e.g., systems based on taking a fixed percentage off of billed charges rather than historical charges) the system was not considered prospective. As discussed in Section 4, we considered, for completeness, mixed retrospective-prospective systems (i.e., systems that make payments based on billed charges up to a ceiling which could be binding) as prospective.

As was the case with contacting the most knowledgeable individual, we cannot be totally certain that all of the prospective plans administered for hospital outpatient services were identified. Again, we believe that in the vast majority of

cases we collected valid information as to whether or not the payer had a prospective payment plan.

2.2.4 Gathering Follow-Up Information

For each prospective payment plan identified, whether actually implemented or still in the developmental stage, information was requested in the following broad areas: all cost and data elements; a description of any patient classification system; the unit of payment; how payment rates are set, including payment limits; and how and when payment rates are increased. In addition, qualitative information on the perceived advantages and disadvantages of such systems was requested. All available written documentation pertinent to the design and implementation of each plan's system was obtained. In those cases where written information was not obtainable, as much detail as possible was elicited via telephone conversations with the individuals responsible for designing and implementing the system. The information that was obtained was not always complete, usually because either respondents did not wish to share information they considered proprietary or the plan in question was still under development.

For each set of documentation received, details and unclear elements of both the design and implementation of that particular system were clarified through additional telephone conversations with knowledgeable persons.

SECTION 3. DESCRIPTION OF GENERAL FINDINGS

3.1 GENERAL FINDINGS

Table 1 summarizes the number and types of organizations contacted, the number of plans found which set prospective payment rates for hospital outpatient or ASC services, and the number of plans for which written or verbal documentation was provided. Of the 203 organizations contacted, 15 were found to have prospective pricing plans either in place or in a developmental stage. Four of the organizations with plans currently in use provided written documentation describing the design of their plans, while eight other organizations discussed the details of their plans over the telephone. Three organizations with plans would not provide us with detailed information because they considered it proprietary. There were three plans which were currently in a developmental stage.

Of the over 80 insurers and PPOs contacted, eight had plans currently in use. Three had plans under development. Information was collected from nine insurance and PPO plans which have prospective payment rates in place and all of those with plans under development. Eight of all plans in place or under development were offered by Blue Cross/Blue Shield (BC/BS) member plans. We contacted 65 corporations, 10 business coalitions, and 39 other organizations (TPAs or UR firms). Neither the corporations nor the business coalitions had prospective plans for outpatient services, and only four other organizations did.

Notice from Table 1 that a higher proportion of plans contacted through leads had prospective plans, and plans identified from leads represented two-thirds of the responding organizations which have plans. This reflects the fact that the people who are actively involved in the private sector

Table 1

Number of Organizations Contacted, Number with Prospective Plans, and Number Providing Information

Type of Organization	Number Contacted	Number Found to Have Prospective Plans in Use or Under Development*	Number With Plans in Use That Provided Information		Number With Plans Under Development
			Written	Verbal	
Insurors					
Leads	20	11	4	4	3
Top-Ranked Non-Leads	69	1	0	1	0
Corporations					
Leads	14	0	0	0	0
Top-Ranked Non-Leads	51	0	0	0	0
Third-Party Administrator/UR Firms					
Leads	12	2	0	2	0
Top-Ranked Non-Leads	27	1	0	1	0
Business Coalitions					
Leads	0	0	0	0	0
Top-Ranked Non-Leads	10	0	0	0	0
Total	203	15	4	8	3

* Excludes organizations with prospective plans that were unwilling to provide us with information. There were a total of three of these organizations.

reimbursement field have substantial knowledge of the payment initiatives taking place.

3.2 THE SCARCITY OF PROSPECTIVE PLANS AND CURRENT PAYMENT METHODS

The plans that were found to pay for services prospectively will be described more fully in Section 4. However, since so few plans were found, it is natural to explore: 1) why prospective payment plans for hospital outpatient and ASC services are not more prevalent; and 2) how private payers currently pay for these services.

3.2.1 Potential Reasons Why Prospective Plans are Not More Prevalent

There are a number of possible reasons why prospective payment plans for hospital outpatient and ASC services are not more prevalent, and these reasons are not mutually exclusive. First, many payers are only now responding to rising outpatient costs and thus have not yet implemented a system. These same payers may also be waiting for HCFA to develop a system for Medicare before considering development of their own prospective payment systems. It was clear from our telephone contacts that many payers are very interested in innovations in this area, and some indicated that, like us, they are also seeking information on what types of prospective payment plans are under development or in use.

A second reason why prospective plans are not prevalent is that various barriers exist to the successful implementation of such systems. The most frequently cited problem was the lack of uniform or adequate data on which to base a payment system. The lack of data on use and costs of hospital outpatient services stems in part from the nature of these types of services. Unlike inpatient hospital care, the provision of outpatient care is

characterized by multiple providers and multiple visits, thus increasing the difficulty of identifying and paying for a discrete case or unit of service. The majority of private sector payers probably lack the detailed billing data (e.g., CPT-4 codes) or cost data to price services--a necessary ingredient to assess the nature and intensity of outpatient services that are provided and for which payment is made.

Another barrier to implementing prospective payment systems is payers' lack of market power. Because of limits in their ability to set their own prices, smaller payers are unlikely to negotiate a successful prospective payment system with providers. It is not too surprising that the BC/BS plans are more likely to be actively involved in prospective payment for outpatient services. Some Blues plans have enough buying power in their regional markets to facilitate the development of prospective systems with providers.

Finally, at least one insurer mentioned the problem of balance billing, which leads to greater out-of-pocket costs for the enrollees in such plans. If rates set by the insurer are much lower than charges, hospitals are likely to seek payment from patients for the balance of the charges. Patients, in turn, might complain to their insurers and/or their employers, which could undermine the marketability of the plan itself.

3.2.2 Current Payment Methods

This section provides an overview of the types of payment methods, aside from prospective types, that are generally in use by the organizations that we contacted. The payment methods for insurers/PPOs, corporations, business coalitions, and TPA/UR firms are described below.

While a few other BC/BS plans are beginning to develop prospective payment systems, the majority of other insurers are not active in this area. Of those insurers contacted, many negotiate rates for outpatient facility services with preferred providers in exchange for the expectation of increased service volume. This type of payment arrangement is not prospective because it involves discounting from billed charges. Thus, it can be considered in the category of discounted fee-for-service. Systems based on negotiation would not be useful models for HCFA to follow because of the administrative burden associated with bargaining with thousands of providers.

Among those insurers who negotiate rates with preferred providers and have established PPO-type plans, the negotiation processes are similar. These insurers typically have their own data bases of charges, or use charge data, for comparative purposes, from the Health Insurance Association of America. Their aim is to negotiate reimbursement levels based on the 85th or 90th percentile of the distribution of charges, or to achieve a 10 to 15 percent discount off charges for all procedures.

The payment arrangements in many cases vary by class of service (e.g., ambulatory surgery, clinical laboratory, radiology services, etc.), specific procedure, or type of facility. Some insurers use relative value scales (RVSs) and conversion factors to establish reimbursement rates for laboratory or radiology procedures. In the case of laboratory charges, several insurers mentioned the use of either the McGraw-Hill or California RVS as the relative value scale. The factors that are used to convert relative value units into dollars are often negotiated, but may be selected in a such a way as to provide payers with a discount off charges. Methods of payment also were found to vary for other service types such as emergency room or mental health services.

Due to the rapid increases in the cost of providing employee health benefits, corporations are faced with a wide range of concerns about containing their health care costs. Some payers are looking at the potential costs of providing new benefits such as long-term care coverage and are not concentrating on changing established reimbursement methods. While several payers have instituted policies that require certain procedures to be performed on an outpatient basis, thus increasing their outpatient costs, they are just now beginning to turn their attention to the pricing of outpatient services. Other corporations responded that if an easily adaptable system was to be developed they would consider its implementation. As with the insurers, many payers indicated that they are awaiting HCFA's lead in this area.

While none of the business coalitions have a system in place, one coalition has conducted a pilot study of prospective pricing for outpatient services. Twenty-six hospitals disclosed their fees and these fees were given to client companies. The companies then have comparative charges from area providers on which to make their contracting decisions. Since there were rather large differences in prices, it was the hope of the coalition that disclosing fees in this manner would encourage hospitals to undercut one another and make prices more competitive. An evaluation of this system is forthcoming and the issue of pricing is next on the coalition's agenda.

Most efforts by business coalitions basically involve attempts to develop purchasing power and thus be able to influence price setting for outpatient services. In one case, several small companies pooled together and joined a group purchasing organization. Such an organization can provide statewide data and purchase services for all the participating companies. Despite these efforts, business coalitions still generally face the same constraints as insurers, particularly in

the lack of necessary market power to negotiate reimbursement rates for outpatient services.

TPAs and UR firms are utilizing strategies similar to insurance companies. While TPAs in general were reluctant to share information they considered proprietary, many of them also negotiate rates in a PPO-type arrangement and base their reimbursement levels on discounts off charges. TPAs also tended to be more specialized, or process claims for particular services, such as vision-related or prescription drug services. In some cases, TPAs process inpatient bills but not claims for outpatient services. UR firms tend to focus their efforts on innovations for controlling service volume (e.g., pre-certification, second surgical opinion, clinical standards, etc.) rather than price.

SECTION 4. DESCRIPTION OF PROSPECTIVE PLANS

4.1 OVERVIEW

As discussed in the previous section, only fifteen of the 203 organizations that we contacted had prospective payment systems for outpatient services in place or under development and were willing to provide us with at least some verbal or written information. Twelve of these were currently using a system for reimbursement and three had systems under development. A detailed synopsis of each plan for which written documentation was provided appears in Appendix A. Appendix B includes synopses of plans for which information was collected over the telephone and synopses of plans that are under development.

The BC/BS plans were eager to provide us with written documentation of their system and were interested in spending the time necessary to guide us through their methodology. TPAs, UR firms, and PPOs were much more guarded. A few considered the actual groupings they had developed for outpatient services to be proprietary. One mentioned that the development of their system required the analysis of a large amount of claims data, and considered what they had developed as their edge over competitors. Despite their cautious nature, from phone interviews, we were able to gain a general insight into their systems.

With the exception of systems that are still under development, none had gone as far as to include a patient classification system. Three-fourths of the plans were relatively new, having been implemented within the last four years. All were relying on data that is currently required for Medicare billing--either the ICD-9 procedure code or the CPT-4 code. Most were grappling with how best to approach the issue of setting prices prospectively and were convinced that their

efforts at controlling volume through utilization review alone were unlikely to slow the increase in outpatient expenditures.

Some of the systems may not truly be prospective. Both BC/BS of North Carolina and BC/BS of Kansas pay the "lessor of charges or the established rate cap." BC/BS of Minnesota establishes target per service rates but reimburses on the basis of charges. At year-end if a hospital's per service charge exceeds the target, the hospital refunds the excess to BC/BS. Conversely, if savings over targeted per service rates were achieved, the hospital and BC/BS split the savings evenly. Because the payment caps for both plans are prospective, and the caps may be binding, we have included these plans in the discussion of prospective systems.

4.2 GENERAL FEATURES OF THE PROSPECTIVE PLANS

4.2.1 Types of Services

Eleven of the twelve plans currently used for reimbursement have established prices for selected ambulatory surgical services (either targeted procedures or all procedures on the approved list of outpatient surgeries). The focus on ambulatory surgery is not surprising as it is much easier to define a unit of care and resource use does not vary as widely for surgical procedures as it does for medical procedures. The number of surgical procedures approved for reimbursement on an ambulatory basis varies a great deal, as does the number of procedures targeted for prospective prices. Prospective rates have been established for anywhere from 50 procedures to over 1400 procedures.

Some payers have targeted high cost, high volume ambulatory surgical procedures for prospective pricing because such procedures account for a large share of all hospital outpatient expenditures. BC/BS of North Carolina, for example, found that

only fifteen surgical procedures performed in the hospital outpatient department accounted for more than sixty percent of all hospital outpatient claims dollars in 1986. BC/BS of Virginia experienced a similar pattern with 200 procedures accounting for 80 percent of their outpatient costs. Targeted procedures included cataract lens procedures, arthroscopies, endoscopies, laparoscopies, cystoscopies and tonsillectomies, to name a few. Of the systems currently being used for reimbursement, nearly half used this approach.

Many plans have developed simple payment categories for high cost, high volume procedures. BC/BS of Kansas exemplifies this approach. In this case, 24 payment categories have been defined. The definition centers around the two or three digit ICD-9-CM procedure code. For example, rhinoplasty comprises one category. Included in this category are procedure codes 21.84 through 21.87. Each payment category is subject to a maximum allowable payment (MAP). Slightly more than 100 procedures have been incorporated into the MAP system. Prices were initially set at the 75th percentile of prevailing charges in 1984 and have since been trended for inflation on an annual basis at a rate that lies between the medical Consumer Price Index (CPI) and the overall CPI.

A major consideration for third-party payers is the administrative simplicity of the system. As a result, payment categories developed often include procedures of widely varying resource use or charges. Only three plans are using systems which group surgeries by relative resource use: BC/BS of Virginia; CAPPCARE; and BC/BS of North Carolina. Since 1985, BC/BS of Virginia has paid a set rate for ambulatory surgery for all providers in the state of Virginia. Six payment groups were established through the use of cluster analysis, the advice of a medical panel, and judgement. Groupings were initially made on the basis of charge history. This was further refined through

the use of detailed cost information made available by a few providers.

CAPPCARE, in 1982, grouped surgeries into one of four groups based on average surgery time and the number of nursing personnel used. This approach was supplemented by the use of a medical panel. CAPPCARE has identified 1,435 procedures approved for ambulatory surgery. They note that the payment groups they have established closely resemble HCFA's current groupings for surgery performed in ambulatory surgical centers.

BC/BS of North Carolina group 1,200 approved procedures into one of 12 payment categories. A variety of sources were used to establish relative resource use, such as the California Relative Value Scale, the charge history, the usual place of service (i.e. physicians' office, free standing ambulatory surgery center, or hospital inpatient), and HCFA's four payment categories. Information was also obtained on surgery time and incidentals used in the surgery (medications or supplies). Their approach has been in use since 1985.

None of these organizations have done a systematic evaluation of how well the established payment groups predict resource use. Neither do they have a systematic method for evaluating changes in resource use that might occur as a result of technological developments. For all three, new technologies were added, if done frequently enough, to one of the existing payment groups. BC/BS of Virginia was also considering a re-evaluation of resource use, similar to the process used to originally develop the six payment groups.

Only two plans paid prospectively for medical services, and both did so for surgical services as well. BC/BS of Minnesota established payment categories for such services as radiation therapy, renal dialysis, chemical dependency, and nervous and

mental disorders. They also had two catch-all categories--emergency services and all non-emergency services not specifically defined in other categories. The latter category includes such diverse items as urinalysis and chemotherapy. A set rate was paid per procedure, defined by either the Uniform Bill (UB-82) revenue codes or ICD-9-CM procedure codes.

Alta Administrators has developed a five-tiered classification for emergency services. Patient characteristics, such as whether the patient was conscious or breathing, and disposition of the case (e.g. admitted as inpatient, death) is used to define the tiers. Payment is made per encounter. The distinctions between the tiers, however, are quite blurred and there is great room for "gaming" this system.

4.2.2 Data Requirements

The data that support most of these systems are generated by charges. Few payers command the market power necessary to make cost reports mandatory (an exception is some BC/BS plans which base prices or were planning to develop prices based on costs). Clearly, one problem in containing costs to the payer (i.e., paid charges) is the lack of information on the resource costs of providing hospital outpatient and ASC services. This is compounded by the fact that even payers with access to cost report information do not obtain cost data broken down finely enough to measure the facility costs of individual procedures.

There is little in the way of information for classifying services in detail which also is problematic. In most cases, only ICD-9-CM procedure and diagnosis codes are available. Thus, it would be difficult to measure the charges associated with medical services or with very specific procedures (e.g., those classified by the CPT-4 coding system).

4.2.3 Payment Unit and Establishment of Payment Rates

For surgical plans in general, the payment unit included all ancillary tests performed at that facility on the day of the surgery, with the exclusion of x-ray and lab tests (except for common blood or urine tests). Some payers had broadened this window of time to 24 hours prior to surgery. Some included the week prior to surgery.

Further bundling of services, in terms of establishing the definition of a case, was also evident. Tonsillectomy was mentioned as a procedure for which defining a case was relatively easy. Cases were defined not in terms of all care provided from the first contact with the health care system for a given diagnosis, but all care subsequent to the positive diagnosis of a specific surgical problem. Thus, early diagnostic testing and cognitive evaluation services were excluded. In some instances, global fees included physicians' fees and all follow-up care, as well as all lab work-up incident to the surgery, anesthesia, wages for certified registered nurse anesthetists, implants and prostheses. Providers were sometimes negotiating with payers for a greater bundling of services, thus retaining the revenue for diagnostic work that was increasingly being performed in a physicians' office or in independent laboratories.

Almost all of the organizations with plans set rates through negotiations or competitive bids with preferred providers. As a result, rates were individually tailored to the facility. In the course of negotiations, payers frequently kept in mind charges that would be paid to other facilities for a similar service. Thus, lab and x-ray fees might be capped at an amount that would have been paid had the tests been performed in a physicians' office. Similarly, rates paid to hospital outpatient departments for ambulatory surgery were sometimes capped at levels that would have been paid in a freestanding ambulatory surgery center.

Only two plans currently set prospective rates that were binding for all facilities within a given area. BC/BS of Kansas had established five peer groupings for hospitals based on bed size or location in major urban areas. Prospective rates were developed for each peer group, although rates were the same for the three peer groups which distinguished hospitals by licensed bed size. BC/BS of Virginia paid a fixed fee which applied to both freestanding ambulatory surgery centers and hospital outpatient departments, regardless of their size or location. BC/BS of Virginia noted that they were now achieving discounts off normal charges that varied from 10 percent at some facilities to 70 percent at others. Both plans, however, mentioned problems of provider participation. BC/BS of Virginia is considering the use of geographic distinctions and developing different rates for sole community hospitals.

Negotiation with providers was found to be an important tool in rate-setting. These negotiations often centered around historical charges. As one payer noted, a large database on charges from a substantial number of providers was one of the prerequisites to establishing prospective prices, as opposed to obtaining a discount off charges. Negotiation is also important for establishing values for some of the parameters of the prospective systems (e.g., the inflation index that should be used and the conversion factor for services paid for under a relative value scale). Multi-year contracts were frequently "evergreen", or binding until either party wished to enter into negotiations again. For multi-year contracts, a variety of approaches to trending rates for inflation were used. Some used the medical CPI, others used the Medicare hospital market basket and others used the overall CPI. Payers endeavored to set a rate that was lower than the medical CPI. One payer used the hospital market basket published in the newsletter Rate Controls that had been developed by a private consultant.

The pricing of new technology was also mentioned as a difficult problem. Most payers paid for new technologies on the basis of reasonable and customary rates until a sufficient charge history had been established to develop a prospective rate. Two technologies that were mentioned as being particularly troublesome were magnetic resonance imaging and lithotripsy.

Consumer resistance to balance billing was mentioned earlier as a possible impediment to the development of prospective payment plans. Nearly all the plans had incorporated a "hold harmless" clause in their provider contracts which prohibited balance billing.

4.3 POSSIBLE LIMITATIONS FOR PLAN EFFECTIVENESS

As described in Section 3, there were two large barriers to the implementation of prospective systems in the private sector--lack of data availability and lack of market power. These two factors are also likely to impact the ability of these plans to contain cost.

4.3.1 Lack of Substantial Market Power

Few prospective plans have comprehensively evaluated the extent to which these pricing mechanisms had helped contain costs. In general, there was a sense that they had slowed the rate of increase in prices for outpatient procedures. Many payers appreciated the greater ability to predict financial outlays under prospective pricing as opposed to charge-based systems.

However, there are reasons to believe that these plans will not be highly effective in containing costs. These relate directly to a payer's buying power in a particular market. First, under some plans, the payment cap, rather than the payment

rate itself, is set prospectively. This gives less incentive for providers to hold down charges, especially if it is thought the payment cap next year will be affected by charges today. Second, key cost containment aspects of the systems are negotiable, such as the conversion factors for services valued under an RVS and the inflation adjustment factor.

4.3.2 Data Limitations

Many of the data problems which were generic to hospital outpatient departments are illustrated in Blue Cross/Blue Shield of Western Pennsylvania's (BC/BS of WPA) work in developing Patient Management Categories (PMCs) for ambulatory care (Young et al., 1986). BC/BS of WPA analyzed outpatient claims from more than 100 facilities over a three month period. Hospital outpatient departments, as a standard, submit UB-82s to third-party payers. UB-82 bills can incorporate as many as five ICD-9-CM diagnosis codes, three ICD-9-CM procedure codes and numerous UB-82 revenue codes for ancillary services for each patient. UB-82 codes are revenue codes designating cost centers in the hospital, such as emergency room, diagnostic x-ray, pharmacy, or ambulatory surgery. More than 90 percent of all outpatient claims had no ICD-9-CM procedure code recorded. Of the bills with only ICD-9-CM diagnosis codes recorded, diagnoses were frequently non-specific and represented a wide array of charges. For example, charges for the ICD-9-CM diagnosis code 789.00, abdominal pain, ranged from $3 to $1,294. Even of the claims with ICD-9-CM procedure codes, there was wide charge variation within a particular facility as well as between facilities. Variation in charges not only reflected widely divergent treatment protocols for patients with a similar diagnoses, but also reflected variations in cost accounting and coding practices among facilities.

While accounting practices and billing procedures are likely to become more standardized as Medicare demands more information on outpatient procedures, the lack of specificity in ICD-9-CM procedure codes is widely recognized. Medicare currently requires CPT-4 codes on all hospital outpatient department and ASC bills. Many payers were in the process of converting their billing requirements to CPT-4 codes, which provide much greater descriptive ability as they are far more numerous.

4.4 PLANS UNDER DEVELOPMENT AND FUTURE TRENDS

Of the three plans under development, two significantly depart from the systems that are currently being used. Dr. Leo Lichtig of Empire BC/BS is currently seeking funding for the development of Acute Patient Care Episodes. This patient classification system would include both surgical and medical procedures and incorporate inpatient as well as outpatient care. The focus is on defining an episode of care. Dr. Lichtig envisions the grouping of episode types into Major Clinical Categories (MCCs). Two prototypes, for maternity and renal services, are currently being investigated.

The aforementioned classification system, PMCs, developed at BC/BS of WPA represents a second developmental payment system. This classification system was originally developed to assign relative cost weights for inpatient care. More recently the concept was extended to outpatient care, with the objective of integrating outpatient and inpatient reimbursement mechanisms. The project identified a list of procedures which are performed on an inpatient basis which could safely be performed on an outpatient basis. Relative cost weights were assumed to be the same for outpatient services as for inpatient services. Costs for specific services were mapped into UB-82 revenue codes for ambulatory services. Due to the ambiguous definition of UB-82 revenue codes, differences in coding practices among facilities,

and the broad range of services covered under one code (e.g., operating room), payment categories represent services with wide ranges of resource use. As such, PMCs are not currently being used for reimbursement. Persons at BC/BS of WPA felt that until providers systematically submitted more detailed information with bills for ambulatory services, such as the CPT-4 code, PMCs could not be adequately used for reimbursement.

Many private payers that did not have prospective payment systems in place were at least undertaking the step of improving their outpatient claims data. Some had purchased Medicare's ambulatory surgery center "grouper" and were looking at the feasibility of using such a system for their own payment purposes. Others had purchased the AVG software from Health Systems International and were using this to improve their claims data.

It is likely that two trends will continue in the future. First, private sector payers will continue to rely on HCFA to take the lead in reforming payment systems. Second, these payers will seek to form coalitions that have the necessary purchasing power to impact prices in the marketplace.

SECTION 5. CONCLUSIONS AND IMPLICATIONS FOR HCFA

Our contacts with numerous private payers who have a large market presence indicates that few have developed prospective payment systems for hospital outpatient or ASC services. In broad terms, the following features characterize the few plans using prospective payment:

- No patient classification systems are used.
- The 12 payment systems currently being used for reimbursement all cover the facility services associated with ambulatory surgery, except for one system that sets rates solely for laboratory and radiology procedures. Two of these plans also cover the facility services associated with hospital outpatient medical care.
- Most of the plans covering services associated with surgery established payment rates only for high volume/high cost surgical procedures.
- Of the 11 plans covering the facility services associated with surgical procedures, 9 cover procedures in both ASCs and hospital outpatient departments, while two cover only ASC procedures.
- The "time window" for defining surgical procedures varies as does the extent of bundling of facility ancillary charges into a procedure's payment rate. The actual calendar day of surgery, or the period within 24 hours of the surgery, are commonly used definitions.
- Plans exhibit flexibility in that various design aspects vary by market area and/or hospital (e.g., whether or not parameters such as inflation trend factors or conversion factors are negotiable).
- Plans which did not incorporate justifiable differences in facility costs were experiencing problems with provider participation.
- The plans generally offer only limited potential for per unit cost-savings since: 1) for some plans, payment is not strictly prospective (e.g., year-end adjustments in payments are used based on a per-service prospective cap); and 2) some components of the system, such as conversion factors for relative values, or the extent of

discounts, are negotiable. The more market power a payer had, the more stringent prospective rates could be.

We can conclude that, at this time, private payer systems probably cannot contribute substantially to the design of a Medicare prospective system for outpatient services. This is true for a variety of reasons. First, private sector payers are not using any innovative patient classification systems, let alone one that could be considered an alternative to AVGs for medical care. Second, many of the plans simply mimic Medicare's system for ASC services. Third, the data that private sector payers have available are no better, and are usually poorer than, the data that Medicare has available (e.g., HCFA conducts a periodic cost survey of ASCs, and requires the inclusion of CPT-4 codes on bills). Finally, Medicare has enough market power that it can set firm prospective rates and does not need to resort to negotiation as a payment strategy.

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APPENDIX A

SYNOPSES OF PLANS WITH WRITTEN DOCUMENTATION OF PAYMENT METHODS

SYNOPSIS OF PAYMENT METHODS

TYPE OF ORGANIZATION: Private Insurance
NAME OF ORGANIZATION: Blue Cross/Blue Shield of North Carolina

PLAN NAME AND SERVICES, AND FACILITIES COVERED: Ambulatory Surgery Program. Over 1200 procedures approved for ambulatory surgery in free standing ambulatory surgical centers are covered. Hospital outpatient departments are still paid on a fee-for-service basis.

DATE IMPLEMENTED: 1985

DEFINITION OF SERVICE GROUPS: There are 14 payment categories, of which two are presently vacant. BC/BS of North Carolina sought to group services in terms of relative resource use. Several guides were used in establishing these payment groups: the California Relative Value Scale, the charge history, and the usual place of service (i.e. physician's office, free standing ASC, or hospital inpatient) and Medicare's four ASC payment groupings. From outpatient reports further information was gathered on the time involved to perform the surgery and incidentals (e.g. medications or supplies). The final groups were subjected to review by a medical panel. In general, groups progress in terms of complexity of the surgical procedure. For example, lens procedures are in Group 10. Arthroscopies are in Group 11. Gall bladder removal is in Group 13. The unit of payment is the surgical procedure. However, if more than one procedure is performed, the least complex is reimbursed at fifty percent. If more than two procedures are performed, this triggers a retrospective review. There is some bundling of services in that any ancillary tests performed that are incident to the surgery are included. This refers to basic blood work and urine tests. Anesthesia and the services of certified registered nurse anesthetists (CRNAs) are also included. Diagnostic procedures, such as x-rays or ekgs, are reimbursed separately. Prostheses and implants are also reimbursed separately.

DATA REQUIREMENTS: Both the CPT-4 code and the ICD-9 procedure code are required.

BASIS FOR DETERMINING RATES: Rates are determined through provider negotiations. They are based on volume and comparable rates for other facilities of the same type. There is not a blanket fee schedule which applies to all ASCs. Rates are not truly prospective in that providers are paid the lessor of charges or the established fee cap.

TYPE OF ORGANIZATION: Private Insurance
NAME OF ORGANIZATION: Blue Cross/Blue Shield of North Carolina (Continued)

ADJUSTMENT FOR INFLATION: Rates can be renegotiated annually, if the provider or BC/BS wishes to enter into negotiations. If not, rate increases are based on a blend of the medical CPI, the overall CPI, and the charge history. Facilities also provide BC/BS with an income statement.

ADJUSTMENT FOR TECHNOLOGICAL CHANGE: Price changes resulting from technological change are accounted for in the same manner as price changes resulting from general cost inflation. New technologies are added on a case by case basis. They are only added if they are done frequently.

BALANCE BILLING CLAUSE: The contracted facility is subject to a "hold harmless" clause which prohibits balance billing.

ADVANTAGES AND DISADVANTAGES: Some facilities have been reluctant to share financial information with BC/BS. This affected provider participation in one instance. In applying this method to HOPDs, more services would need to be incorporated. There are several types of procedures, for instance the injection of a myelogram, which are only performed in a HOPD. In addition, the volume of claims from HOPDs would be considerably greater which is a constraint as some of the review and payment is currently performed manually.

SYNOPSIS OF PAYMENT METHODS

TYPE OF ORGANIZATION: Private Insurance
NAME OF ORGANIZATION: Blue Cross/Blue Shield of Virginia

PLAN NAME AND SERVICES, AND FACILITIES COVERED: Ambulatory Surgery Program. Covers over 700 procedures approved for ambulatory surgery in freestanding ambulatory surgery centers and hospital outpatient departments.

DATE IMPLEMENTED: 1985

DEFINITION OF SERVICE GROUPS: There are 6 payment groups. These were developed through a combination of cluster analysis (based on resource use), advice of a medical panel and professional judgment. The unit of payment is the procedure although, if more than one procedure is performed at the same site, at the same time, they reimburse at 100 percent for the primary, 50 percent for the secondary, and 25 percent for the tertiary procedure. Included in the payment are anesthesia, medical supplies, medications, and non-physician labor. All testing incident to the surgery is also included. There is a 24 hour time window established to define these services. Diagnostic testing is reimbursed separately. Implants are also reimbursed separately.

DATA REQUIREMENTS: Currently the system is based on ICD-9 procedure codes. They are moving to CPT-4 codes.

BASIS FOR DETERMINING RATES: Used a combination of historical charges and historical costs to determine relative resource use of approved procedures. Reimbursement rates for each category were based on charges associated with the procedures in the median frequency group within a payment category. These charge based rates were reduced by a cost to charge ratio based on detailed cost information obtained from 10 to 15 selected providers. Rates are the same for ASCs as for HOPDs, although adjustments can be made depending upon whether the provider does more procedures with general as opposed to local anesthetic within a payment category. They are considering making payment adjustments if the facility is a sole community hospital or is located in northern Virginia.

ADJUSTMENT FOR INFLATION: Trended yearly on the basis of the Hospital Market Basket Index published in Rate Controls.

TYPE OF ORGANIZATION: Private Insurance
NAME OF ORGANIZATION: Blue Cross/Blue Shield of Virginia
(Continued)

ADJUSTMENT FOR TECHNOLOGICAL CHANGE: There have been no adjustments for technological change, with the exception of adding new procedure codes to the existing categories. There is a plan to undertake another analysis of relative resource use of approved procedures.

BALANCE BILLING CLAUSE: Providers are under a contractual agreement to not balance bill.

ADVANTAGES AND DISADVANTAGES: This pricing scheme has been very effective at saving BC/BS of Virginia money. They obtain on average 25 percent to 45 percent discount off of charges, but the range is anywhere from a 10 percent discount off charges to a 70 percent discount off charges. They are currently experiencing problems with provider participation and are examining ways to reflect justifiable cost differences in the rates. One of their biggest goals was to develop a system that was administratively simple.

SYNOPSIS OF PAYMENT METHODS

TYPE OF ORGANIZATION: Private Insurance
NAME OF ORGANIZATION: Blue Cross/Blue Shield of Kansas

PLAN NAME AND SERVICES, AND FACILITIES COVERED: MAP (Maximum Allowable Payment). Over 100 ambulatory surgery procedures are subject to MAP reimbursement. Procedures that were selected are high cost, high volume, or are primarily performed on an inpatient basis (but were identified as being safe to perform in an outpatient setting). Both hospital outpatient departments and free standing ambulatory surgery centers are reimbursed on this basis.

DATE IMPLEMENTED: 1984

DEFINITION OF SERVICE GROUPS: There are 24 ambulatory surgery categories. Categories are organized around ICD-9 procedure codes. For example, dental procedures, laparoscopy and lens procedures comprise three separate categories. All ancillary tests done within a 24 hour period prior to surgery are included in the payment.

DATA REQUIREMENTS: The four digit ICD-9 procedure code is required.

BASIS FOR DETERMINING RATES: Rates were initially set at the 75th percentile of hospital charges. Hospitals have been grouped into five separate peer groups. Peer grouping is related to licensed bed size or geographic location. Peer Group 1 includes hospitals with 0-49 beds. Hospitals in Peer Group 2 have 50-99 beds and in Peer Group 3, hospitals have 100 beds or more. Peer Group 4 is the city of Topeka and Peer Group 5 is the city of Wichita. As of March 1989, ambulatory surgery payment rates for the first three peer groupings were identical. Free standing ambulatory surgery centers represent a sixth peer group. Rates tend to be lower in this latter group.

ADJUSTMENT FOR INFLATION: Payment rates are adjusted for inflation on an annual basis. A trending factor that lies between the Medical CPI and the overall CPI is chosen.

TYPE OF ORGANIZATION: Private Insurance
NAME OF ORGANIZATION: Blue Cross/Blue Shield of Kansas
(Continued)

ADJUSTMENT FOR TECHNOLOGICAL CHANGE: BC/BS of Kansas has a policy to assign new procedures or technologies to MAPs on the basis of existing procedures of comparable value and result. In practice, new procedures are assigned MAP rates only after they have established a charge history and represent a high cost, high volume procedure. Two new categories include medical resonance imaging (MRI) and mammography.

BALANCE BILLING CLAUSE: The contractual agreement with the provider prohibits balance billing.

ADVANTAGES AND DISADVANTAGES: The major advantage of this system is that it helps control costs and allows for greater ability to control payout. One disadvantage is that the categories that have been identified represent a wide array of different charges even within the same facility. Currently the data available on outpatient services is very weak. Since the end of 1988, they have been gathering data on patient characteristics, such as age, diagnosis and prognosis. There is some discussion of moving toward a CPT-4 based system.

SYNOPSIS OF PAYMENT METHODS

TYPE OF ORGANIZATION: Private Insurance
NAME OF ORGANIZATION: Blue Cross/Blue Shield of Minnesota

PLAN NAME AND SERVICES, AND FACILITIES COVERED: Hospital AWARE Program. Targeted high cost, high volume surgical and medical services are included for selected hospitals. Free standing ambulatory surgery centers are also reimbursed a fixed fee for these procedures, but under a separate schedule.

DATE IMPLEMENTED: 1987 in Minneapolis/St. Paul and 1989 in the greater Minnesota area.

DEFINITION OF SERVICE GROUPS: There are 20 outpatient treatment categories. The categories are defined by general procedure groups. For example, cataract procedures and arthroscopy represent two distinct categories. Some categories are quite broad, such as radiation therapy or emergency services. There are two catch-all categories: other surgery and other non-emergency services. The latter can include such diverse services as urinalysis and chemotherapy.

DATA REQUIREMENTS: The four digit ICD-9 procedure code is required.

BASIS FOR DETERMINING RATES: Rates are determined through negotiations with the hospitals. Hospitals have been grouped into three peer groups. Group A includes 26 hospitals in the Minneapolis/ St. Paul area. Group B includes 20 hospitals in greater Minnesota which have a large volume of BC/BS business. All other hospitals are in Group C. Hospitals in Group C are still paid on a reasonable charge basis. Payment is not prospective, in the sense that target rates per service are established, but hospitals are paid on a charge basis subject to year end reconciliation. If a hospital's per service charge exceeds the target, the hospital refunds the excess to BC/BS. If savings over targeted per service rates were achieved, the hospital and BC/BS split the savings evenly. Rates for ASCs tend to be lower.

ADJUSTMENT FOR INFLATION: Rates are renegotiated annually. HCFA's hospital market basket is used in the negotiation process.

ADJUSTMENT FOR TECHNOLOGICAL CHANGE: This is negotiated on an annual basis. Payment categories may be added or broadened.

TYPE OF ORGANIZATION: Private Insurance
NAME OF ORGANIZATION: Blue Cross/Blue Shield of Minnesota
(Continued)

BALANCE BILLING CLAUSE: BC/BS of Minnesota has a "hold harmless" clause in provider contracts which prohibit balance billing.

ADVANTAGES AND DISADVANTAGES: The major advantage of this system is that it is administratively simple. It was developed and implemented in less than six months. In addition, the broad category groupings simplify annual negotiations. The disadvantage is that budgeting and cash flow are still difficult to project as claims are paid on a charge basis. Also, the categories, particularly the catch-all categories, encompass procedures with wide variations in charges. They are looking at moving toward broader groupings, similar to HCFA's groupings for ASCs and basing the rates on median charges. The Hospital AWARE program does very little to control outpatient utilization.

APPENDIX B

SNYOPSES OF PLANS FOR WHICH INFORMATION WAS COLLECTED OVER THE TELEPHONE AND SYNOPSES OF PLANS UNDER DEVELOPMENT

SYNOPSIS OF PAYMENT METHODS

TYPE OF ORGANIZATION: Third Party Administrator
NAME OF ORGANIZATION: Alta Administrators

PLAN NAME AND SERVICES, AND FACILITIES COVERED: Have developed prospective prices for several hundred high cost, high volume ambulatory surgery procedures, lab and x-ray services and emergency services. These arrangements are made with both hospital outpatient departments and free standing ambulatory surgery facilities.

DATE IMPLEMENTED: 1988

DEFINITION OF SERVICE GROUPS: They have developed 20 to 25 groups of ambulatory surgery procedures. Payment groups are based on ICD-9 codes. These groups include those surgeries that are most frequently performed on an outpatient basis (i.e. cataract surgery, arthroscopy, etc.). Rates include anesthesia and all services incident to the surgery performed on the day of surgery. With some providers the rates include physician services. Emergency services are grouped into five tiers of increasing severity. Patient characteristics such as whether the patient is conscious, or breathing, and disposition of the case (e.g. admitted as an inpatient, death) are included to define these categories. The distinctions between the tiers, however, are quite blurred and there is great room for abuse. The California Relative Value Scale or the McGraw Hill relative value scale is used to reimburse for lab and x-ray services.

DATA REQUIREMENTS: The four digit ICD-9 procedure code is required. For emergency services, the hospital must report what tier the service falls in to.

BASIS FOR DETERMINING RATES: Fees are established on the basis of competitive bids and negotiations. The conversion factor for lab and x-ray is set at a level to achieve a targeted discount off of charges. The contract is "evergreen" in that it rolls over into a subsequent year unless either party would like to renegotiate. Fees vary by facility.

ADJUSTMENT FOR INFLATION: Fees are increased annually on the basis of the medical CPI. Some services are increased on the basis of one of the more disaggregated components of the medical CPI.

TYPE OF ORGANIZATION: Third Party Administrator
NAME OF ORGANIZATION: Alta Administrators
(Continued)

ADJUSTMENT FOR TECHNOLOGICAL CHANGE: This is adjusted for in the negotiation process.

BALANCE BILLING CLAUSE: All providers are subject to a clause which prohibits balance billing.

ADVANTAGES AND DISADVANTAGES: One of the advantages of the system is that with a pre-set price, outlays are more predictable. A disadvantage is that, on occasion, they may pay more than the provider's charge for a particular service. Providers are reluctant to enter into a contract for fixed emergency service fees, as Health Risk Management cannot guarantee volume for these types of services. The current classification system for emergency services is unsatisfactory as hospitals have too much latitude for how they categorize various patients.

SYNOPSIS OF PAYMENT METHODS

TYPE OF ORGANIZATION:	Preferred Provider Organization
NAME OF ORGANIZATION:	Beech Street
PRIMARY CONTACT:	Doreen Corwin
TITLE:	Vice President
PHONE NUMBER:	(714) 727-9300

PLAN NAME AND SERVICES, AND FACILITIES COVERED: Case rates for selected ambulatory surgical procedures. Select surgical procedures (very few) performed in hospital outpatient departments or freestanding ambulatory surgical facilities which lend themselves to case definition are covered.

DATE IMPLEMENTED: 1988

DEFINITION OF SERVICE GROUPS: Surgical cases have not been defined by Beech Street but have, instead, been proposed by hospitals in order to retain ancillary business (i.e. diagnostic testing). Case definition varies from facility to facility. In some instances, all care related to a particular surgery following initial diagnosis would be included. Prostheses, implants and pre-surgery testing are items that may be included. A general window of time of 24 hours prior to the surgery and the day of the surgery is frequently used. Procedures for which cases have been defined include: tonsillectomy, herniorrhaphy and corneal transplants. Precise case definitions for each provider contract are not readily available and thus could not be provided for this report.

DATA REQUIREMENTS: Hospitals and ambulatory surgery centers submit their usual charge bills. Data on the ICD-9 procedure code and the CPT-4 code are required.

BASIS FOR DETERMINING RATES: As in usual preferred provider arrangements, fees are set on the basis of negotiations, historical charges and a comparison to comparable rates for the same services provided on an inpatient basis or provided at other facilities. Rates are not truly prospective in that the lessor of charges or the established fee schedule is paid.

ADJUSTMENT FOR INFLATION: Contracts with providers are "evergreen" in the sense that fee caps remain in effect until either party wishes to enter into negotiations again. Caps are not automatically increased annually on the basis of an inflation factor.

TYPE OF ORGANIZATION: Preferred Provider Organization
NAME OF ORGANIZATION: Beech Street
(Continued)

ADJUSTMENT FOR TECHNOLOGICAL CHANGE: This is achieved through the negotiation process.

BALANCE BILLING CLAUSE: Facilities are subject to a balance billing clause.

ADVANTAGES AND DISADVANTAGES: Case rates have in some instances achieved substantial savings over previous reimbursement methods for outpatient surgical procedures.

SYNOPSIS OF PAYMENT METHODS

TYPE OF ORGANIZATION: Private Insurance
NAME OF ORGANIZATION: Blue Cross/Blue Shield of Arizona

PLAN NAME AND SERVICES, AND FACILITIES COVERED: Competitive Bidding for Free Standing Ambulatory Surgery Facilities Flat payment rates are established for ambulatory surgery performed in free-standing ambulatory surgery centers. Hospital outpatient departments are currently reimbursed on the basis of a percent discount off charges. They are working on establishing a grouper for surgery in a hospital outpatient department in order to pay prospective rates there. There are also plans to set a cap on x-ray and laboratory fees at the rate that would have been paid if these services had been performed in a physician's office.

DATE IMPLEMENTED: 1987 for ASCs. Others under development.

DEFINITION OF SERVICE GROUPS: The current unit of payment is the ICD-9 procedure code. Rates are established for each one. There are roughly two hundred procedures that have been approved for outpatient surgery. All care incident to the surgery performed on the day of surgery is included in the payment, with the exception of laboratory tests and x-ray exams. They have been looking at HCFA's ambulatory surgery center groupings to use as a means of developing payment categories for ambulatory surgery in both HOPDS and ASCs. This grouper is lacking in comprehensiveness. For example, maternity and obstetrical care are not included. They would like to establish a more level playing field in their reimbursement method for HOPDs and ASCs.

DATA REQUIREMENTS: ICD-9 procedure code.

BASIS FOR DETERMINING RATES: Rates are tailored toward each facility and are established on the basis of competitive bids and negotiations.

ADJUSTMENT FOR INFLATION: Currently rates are adjusted every two years through opening the bidding and negotiation process. They are moving toward the use of more open ended contracts where the trending factor would be one of the items negotiated for the contract.

ADJUSTMENT FOR TECHNOLOGICAL CHANGE: A new price is negotiated for each new technology.

BALANCE BILLING CLAUSE: A contractual agreement with each provider prohibits balance billing.

TYPE OF ORGANIZATION: Private Insurance
NAME OF ORGANIZATION: Blue Cross/Blue Shield of Arizona
(Continued)

ADVANTAGES AND DISADVANTAGES: The major disadvantage to their current system of reimbursement is the complexity of comparing competitive bids for several hundred procedures. In addition, there are problems with up-coding and unbundling of services. Currently the ICD-9 code is too broad. They are moving toward the use of CPT-4 codes.

SYNOPSIS OF PAYMENT METHODS

TYPE OF ORGANIZATION: Utilization Review Company
NAME OF ORGANIZATION: CAPPCARE

PLAN NAME AND SERVICES, AND FACILITIES COVERED: There are 1,435 procedures approved for ambulatory surgery. CAPPCARE has set prospective rates for these in both ASCs and hospital outpatient departments.

DATE IMPLEMENTED: 1982

DEFINITION OF SERVICE GROUPS: Ambulatory surgery procedures are grouped into one of four payment categories. Categories have been established to reflect relative resource use. Resource use was defined by the number of nursing personnel used and the amount of time it took to conduct the surgery. Time sheets were made available by the providers. A panel comprised of physicians and other medical personnel established the four groups.

DATA REQUIREMENTS: The four digit ICD-9 code is required from the hospital and the CPT-4 code is required from the free standing surgery facility.

BASIS FOR DETERMINING RATES: Rates are negotiated annually with each provider. As in usual preferred provider negotiations, the greater the volume, the lower the rate. Rates vary from $300 for the first category to $900 for a cataract lens implant, which comprises the fourth category. Rates for hospital outpatient departments are constrained by rates for comparable services available at free-standing ambulatory surgery centers.

ADJUSTMENT FOR INFLATION: Annual negotiations.

ADJUSTMENT FOR TECHNOLOGICAL CHANGE: Annual negotiations.

ADVANTAGES AND DISADVANTAGES: Hospitals have been reluctant to enter into contract with CAPPCARE at rates paid to free standing ambulatory surgery facilities.

NOTE: This organization was reluctant to disclose much information, but, may be willing to discuss their methodology more in depth with persons from HCFA.

SYNOPSIS OF PAYMENT METHODS

TYPE OF ORGANIZATION: Preferred Provider Organization
NAME OF ORGANIZATION: Healthcare Compare

PLAN NAME AND SERVICES, AND FACILITIES COVERED: Affordable Healthcare, the PPO subsidiary of Healthcare Compare, establishes pre-set rates for its preferred providers. Prospective rates are sometimes established for laboratory and x-ray tests in hospital outpatient departments and ambulatory surgery in free standing ambulatory surgery centers.

DATE IMPLEMENTED: 1987

DEFINITION OF SERVICE GROUPS: Service groups for lab and x-ray and ambulatory surgery are defined on the basis of the California Relative Value Scale. All ancillary tests provided on the day of surgery are included in the payment rate. Further bundling of services, such as the inclusion of prostheses, implants or physician services is negotiated with each facility.

DATA REQUIREMENTS: CPT-4 code.

BASIS FOR DETERMINING RATES: Conversion factors for lab and x-ray fee schedules and rates for ambulatory surgery are negotiated with each facility. Negotiations are based on competitive bidding and historical charges. They noted that few PPOs set prices prospectively. Most obtain a percent discount off of charges. In order to set prospective rates, the payer needs substantial market power and a large data base on paid claims. Data is one of the critical areas where Affordable had an edge. In most cases, multi-year contracts are drawn up.

ADJUSTMENT FOR INFLATION: Trend factors are one of the negotiable features of a provider contract. Affordable usually sets the inflation index below the medical CPI.

ADJUSTMENT FOR TECHNOLOGICAL CHANGE: This is taken into account in the negotiation process.

BALANCE BILLING CLAUSE: Providers are prohibited from balance billing.

SYNOPSIS OF PAYMENT METHODS

TYPE OF ORGANIZATION: Third Party Administrator
NAME OF ORGANIZATION: Health Risk Management

PLAN NAME AND SERVICES, AND FACILITIES COVERED: With some providers, they have developed fixed fees for the top fifty high cost, high volume medical and surgical procedures. These contracts can apply to free standing ambulatory surgery facilities as well as hospital outpatient departments.

DATE IMPLEMENTED: Unknown

DEFINITION OF SERVICE GROUPS: Service groups are CPT-4 based. There is no additional bundling of services.

DATA REQUIREMENTS: CPT-4 code with the ICD-9 code for confirmation.

BASIS FOR DETERMINING RATES: Rates are based on competitive bids submitted by providers. Providers are chosen by arraying bids around HIAA charge data.

ADJUSTMENT FOR INFLATION: Competitive bidding process occurs every two years. Rates between bidding periods are increased on the basis of the overall CPI, which is considerably lower than the medical CPI.

ADJUSTMENT FOR TECHNOLOGICAL CHANGE: This is adjusted for through the negotiations process.

NOTE: This organization was also reluctant to disclose much information.

SYNOPSIS OF PAYMENT METHODS

TYPE OF ORGANIZATION: Preferred Provider Organization
NAME OF ORGANIZATION: MetroCare, Inc.

PLAN NAME AND SERVICES, AND FACILITIES COVERED: Some prospective prices are set for high cost, high volume ambulatory surgery services and x-ray and lab. Arrangements vary with the provider and depend upon market power. Contracts are with hospitals only.

DATE IMPLEMENTED: Unknown

DEFINITION OF SERVICE GROUPS: For ambulatory surgery, selected high cost, high volume procedures have been targeted for fixed pricing. These include procedures such as cataract surgery, arthroscopy and endoscopy. All ancillary services which are performed within seven days prior to the surgery are included in this rate. Diagnostic services, such as x-ray and laboratory, are sometimes paid on the basis of a relative value scale (California Relative Value Scale or McGraw-Hill).

DATA REQUIREMENTS: ICD-9 procedure codes are required from hospitals.

BASIS FOR DETERMINING RATES: Rates are negotiated individually with each facility. In some cases, rates are determined through the competitive bidding process. They may be based on historical charges or rates available at comparable facilities. The conversion factor for x-ray and lab relative value scales are set to obtain a percent discount off of charges. However, the fees paid out are fixed, in advance, and often this schedule is trended forward for a multi-year contract.

ADJUSTMENT FOR INFLATION: The inflation factor is one of the negotiable features of a provider contract. In general, a rate that lies below the expected increase in the medical CPI is obtained.

ADJUSTMENT FOR TECHNOLOGICAL CHANGE: Adjustments are made through the negotiation process. It is difficult to establish prices for a new technology.

BALANCE BILLING CLAUSE: Most contracts have a clause which prohibits balance billing

ADVANTAGES AND DISADVANTAGES: Relative market share determines how strictly rates can be controlled, and as a result, the effectiveness of cost containment efforts varies by market power. The lack of cost data and deficiencies of claims data limit their ability to effectively establish prospective rates.

SYNOPSIS OF PAYMENT METHODS

TYPE OF ORGANIZATION: Private Insurance
NAME OF ORGANIZATION: State Mutual Life

PLAN NAME AND SERVICES, AND FACILITIES COVERED: Laboratory and x-ray services in hospital outpatient departments, independent labs, and physicians' offices.

DATE IMPLEMENTED: Unknown

DEFINITION OF SERVICE GROUPS: Based on the California Relative Value Scale or the McGraw-Hill relative value scale.

DATA REQUIREMENTS: CPT-4

BASIS FOR DETERMINING RATES: Conversion factors are originally set through negotiations.

ADJUSTMENT FOR INFLATION: This trend factor is one of the negotiable features of a provider contract.

ADJUSTMENT FOR TECHNOLOGICAL CHANGE: This is adjusted through payment level negotiations.

NOTE: This organization was also reluctant to disclose much information.

SYNOPSIS OF PAYMENT METHODS

TYPE OF ORGANIZATION: Private Insurance
NAME OF ORGANIZATION: Blue Cross/Blue Shield of Michigan

PLAN NAME AND SERVICES, AND FACILITIES COVERED: Plans are to set prospective rates for ambulatory surgery services, laboratory and x-ray. Approximately 600 procedures have been identified for ambulatory surgery. These are procedures which can be safely performed in an ambulatory setting and are not commonly performed in a physician's office. They also must be performed more than 100 times in a given year.

DATE IMPLEMENTED: Under development.

DEFINITION OF SERVICE GROUPS: The payment unit would be the CPT-4 procedure. There will be no attempt to bundle services at a more aggregate level as there is too much variability in the use of tests by case.

DATA REQUIREMENTS: CPT-4 code, ICD-9 procedure code and normal UB-82 data. They will gather charge data on the basis of CPT-4 codes. This will be used to establish payment rates nine months from now.

BASIS FOR DETERMINING RATES: Rates will be based on historical costs derived from hospital cost reports. Currently BC/BS of Michigan pays at historical costs plus 6 percent. Rates will not be tailored to each provider but would apply to all hospitals or ambulatory surgery centers. They are looking into the legitimacy of recognizing different facility costs based on type or location.

ADJUSTMENT FOR INFLATION: Adjustments in rates would occur on an annual basis and would be increased by the Medicare market basket. The actual method is subject to change as they are in the early stages of development of this system.

ADJUSTMENT FOR TECHNOLOGICAL CHANGE: Not firm at this stage.

BALANCE BILLING CLAUSE: Providers would be prohibited from balance billing the patient.

SYNOPSIS OF PAYMENT METHODS

TYPE OF ORGANIZATION: Private Insurance
NAME OF ORGANIZATION: Empire Blue Cross/Blue Shield

PLAN NAME AND SERVICES, AND FACILITIES COVERED: Acute Patient Care Episodes. This patient classification system would include inpatient and outpatient services. Both medical and surgical procedures would be incorporated.

DATE IMPLEMENTED: Under development.

DEFINITION OF SERVICE GROUPS: The unit of payment would be episode based. Each episode type would be defined as a Major Clinical Category (MCC). An example of an MCC would be "male reproductive renal". There could be as many as 1,000 MCCs defined. Only acute care would be included-- as such the episode definition is limited to one year. Physician services would be bundled in. Two prototypes, for maternity and renal, are currently being investigated.

DATA REQUIREMENTS: This is yet to be established. At minimum the CPT-4 code and ICD-9 code would be required along with some simple patient modifiers, such as age (or for example, birth weight for neonatal cases). The identification of complications or co-morbidities would be essential. Physicians will be involved in defining the patient characteristics that will be important to look at.

BASIS FOR DETERMINING RATES: Do to the difficulty in predicting a course of treatment for outpatient services from initial visits, it may not be feasible to use this system for prospective reimbursement. However, this may be useful in establishing norms of care to be used for retrospective utilization review. This system may be used in conjunction with PACs or PASs for reimbursement purposes.

SYNOPSIS OF PAYMENT METHODS

TYPE OF ORGANIZATION: Private Insurance
NAME OF ORGANIZATION: Blue Cross/Blue Shield of Western Pennsylvania

PLAN NAME AND SERVICES, AND FACILITIES COVERED: Patient Management Categories. Originally developed for inpatient services, these have been extended to include ancillary services (lab and x-ray) and surgical procedures provided in hospital outpatient departments.

DATE IMPLEMENTED: Under development.

DEFINITION OF SERVICE GROUPS: Although the intention was to develop a visit or day of surgery based unit for payment, due to the lack of data linking ancillary services to surgical procedure, the unit of payment is still the service or procedure. These are defined by UB-82 codes.

DATA REQUIREMENTS: UB-82 codes.

BASIS FOR DETERMINING RATES: Cost data were collected from six western Pennsylvania hospitals for inpatient services. It was assumed that the relative values for inpatient services would be the same for outpatient services. Procedure and ancillary service costs were mapped to UB-82 codes. Cost weights were developed based on the weighted average cost for that code. Cost weights for surgical procedures incorporated time units. The longer the amount of time, the higher the cost weight.

ADVANTAGES AND DISADVANTAGES: The major advantage of this system was to put inpatient and outpatient surgical procedures and ancillary services on a more level playing field in order to provide an incentive to use the more inexpensive ambulatory services. The major disadvantage is the use of UB-82 codes as the unit of payment. Due to wide variation in types of services and service costs within a UB-82 code, the system is not recommended for reimbursement. The methodology could be applied to outpatient services using CPT-4 codes once these codes are widely used by HOPDs.

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